

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

15871

FILED APR 18 1953

318

PRIMARY REG. DIST. NO. 1003

State File No.

Registrar's No. 3476

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		State File No.		Registrar's No.			
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>					c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS</u> <u>2129</u>						
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <u>#6 LENOX PL.</u>					d. STREET ADDRESS (If rural, give location) <u>#6 LENOX PL.</u> <u>0</u>						
3. NAME OF DECEASED (Type or Print) a. (First) <u>DR MILTON SEIDEL</u>			b. (Middle)		c. (Last) <u>KISTLER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 1, 1953</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOW</u>		8. DATE OF BIRTH <u>AUG. 12-1869</u>		9. AGE (In years last birthday) <u>83</u> If UNDER 1 YEAR Months Days If UNDER 1 HR. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PHYSICIAN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>			11. BIRTHPLACE (State or foreign country) <u>PA.</u>			12. CITIZEN OF WHAT COUNTRY?		
13a. FATHER'S NAME <u>WILLIAM KISTLER</u>			13b. MOTHER'S MAIDEN NAME <u>JUDITH SEIDEL</u>			14. NAME OF HUSBAND OR WIFE <u>EMMA KISTLER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mr James Macdonald #6 Lenox Pl.</u>						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.					MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary thrombosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Arterio Sclerosis</u> <u>1. Diabetes</u> DUE TO (c) <u>Left kidney stone</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>(2)</u> <u>10 yrs</u> <u>5 yrs</u>	
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)			21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR? <u>4201</u>					
22. I hereby certify that I attended the deceased from <u>3/31/53</u> , 19 <u>53</u> , to <u>4/1/53</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>3/31</u> , 19 <u>53</u> , and that death occurred at <u>6 P.</u> m., from the causes and on the date stated above.											
23a. SIGNATURE (Degree or title) <u>Dr. Jack M.D.</u>					23b. ADDRESS <u>78 S. Kingshighway</u>			23c. DATE SIGNED <u>4/1/53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>			24b. DATE <u>APR. 2-1953</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ODD FELLOWS CEM</u>			24d. LOCATION (City, town, or county) (State) <u>SHENANDOAH PA.</u>			
DATE REC'D BY LOCAL REG. <u>APR 1 1953</u>			REGISTRAR'S SIGNATURE <u>J. C. Smith M.D.</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>L. MULLEN UND. Co.</u>			ADDRESS <u>5165 DELMAR BL.</u>		

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Ronald O. Johnke

Licensed Embalmer No. *3917*

P. O. Address

St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.